STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445476	A. BUILDING _____ B. WING _____	05/06/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST HEALTHCARE SOUTH	1758 HILLWOOD DRIVE KNOXVILLE, TN 37920

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On May 2 - 6, 2011 an annual Recertification Survey and investigation of complaints #s TN 27790, TN27994 and TN27457 were completed. The facility was cited with an Immediate Jeopardy at F-157, F-281, F-333 and F-490, all with a scope and severity of a "J", for failing to prevent significant narcotic medication errors and failing to notify the physician of the errors for one (resident #20) of thirty-one residents reviewed. The facility's failure to ensure residents were free of significant medications errors was likely to cause serious injury, harm, impairment or death to resident #20. An Extended Survey was completed on May 5 and 6, 2011. The Administrator and the Corporate Nurse Consultant were informed of the Immediate Jeopardy on May 4, 2011 at 12:05 p.m. in the Administrator's office. The Immediate Jeopardy was effective from February 22, 2011 through May 6, 2011. An acceptable Allegation of Compliance, which removed the Immediacy of the Jeopardy, was received and corrective actions were validated on-site by the survey team on May 6, 2011. Non-compliance of the Immediate Jeopardy tags continues at a scope and severity of a "D" level for monitoring of corrective actions. The facility is required to submit a plan of correction for all tags.	F 000	**This Plan of Correction is submitted as required under State and Federal law. The facility's submission of the Plan of Correction does not constitute an admission on the part of the facility that the findings cited are accurate, that the findings constitute a deficiency, or that the scope and severity determination is correct. Because the facility makes no such admissions, the statements made in the Plan of Correction cannot be used against the facility in any subsequent administrative or civil proceeding.** Amended POC #2 acceptable	
157	483.10(b)(11) NOTIFY OF CHANGES	F 157	**F157** 1. Resident #20 is no longer at the facility 2/24/11.	

ATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Melissa Hansen — Administrator — 5/27/11

ciency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that feguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 owing the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued participation.

Melissa Hansen Administrator Amended 6/3/11

JUN 03 2011

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F 157 SS=J	Continued From page 1 (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on facility policy review, review of a Narcotic Count Sheet, medical record review,	F 157	The physician was notified of medication error on 2/24/11 by the Director of Nursing. Administrator educated Director of Nursing on 3/4/11 on the Policies and Procedures for narcotic counts, notification of change, and the incident event management procedure. An investigation was begun by the Director of Nursing on 3/4/11. The Pharmacy Consultant was notified of the medication error on 3/2/11, and was involved in the investigation of narcotic count error. LPN #2 is no longer employed as of 3/19/11. 2. An audit of 100% of the liquid narcotic medication sheets was done by the Director of Nursing on 3/4/11. No other residents were identified as being affected. All liquid narcotics records were reviewed by the Regional Director of Clinical Services and a Registered Nurse on 5/4/11. No other residents were found to be affected. 3. Inservice was given to all licensed nursing staff on 3/4/11 – 3/10/11 by Director of Nursing regarding measuring narcotic liquids with return demonstration required.	

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F 157	Continued From page 2 review of the Medication Occurrence Report, and interview, the facility failed to notify the physician when significant medication errors for one resident (#20) occurred of thirty-one residents reviewed. The facility's failure to notify the physician of significant medication errors was likely to cause serious injury, harm, impairment, or death to resident #20. On May 4, 12:05 p.m., in the office of the administrator, the administrator and the corporate nurse consultant were informed of the Immediate Jeopardy. The findings included: Resident #20 was admitted to the facility with diagnoses including Diabetes Type II, reoccurring Congestive Heart Failure, Chronic Obstructive Pulmonary Disease/Oxygen-Dependent, Morbid Obesity, Chronic Anemia related to slow Gastro-Intestinal Bleeding requiring intermittent blood transfusions, Dementia with Depression, and Liver Failure with Blood Disorder diagnosed in December 2010. Review of the nurse's progress notes for February 19, 2011, at 10:15 a.m., revealed, "...Spoke with (names of two sons). Total comfort care agreed. No hospitalization. New order for MSO4 (morphine, a narcotic) and Atropine (decreases secretions)...Will monitor." Review of the physician's orders for February 2011 revealed on February 19, 2011, an order for Roxanol (a liquid morphine preparation) 1-2 mg (milligram) PO (by mouth) q 1 (every one) hour PRN (as needed).	F 157	Facility policy on Administering Controlled Medications was revised by Administrator and Director of Nursing on 5/4/11 to require that two nurses verify and sign off on the Medication Administration Record all liquid narcotic doses less than 5ml. On 5/6/11 this revision was added to the narcotic med pass policy and Med Pass Observation sheet by the Regional Director of Clinical Services and signed by the Administrator and Director of Nursing. All licensed nurses were educated by Regional Director of Clinical Services, Director of Nursing and Admissions Nurse on 5/4/11 – 5/20/11 on the following requirements: verification of any liquid narcotic less than 5 mls by a second nurse who must also initial Medication Administration Record. Inservices also included the Five Rights of Medication Administration, alert charting to be initiated on every shift for seventy-two hours after a medication error, timely notification of the Physician, Director of Nursing and the Administrator after a medication error. The Medical Director and Pharmacy Consultant will be advised by the Administrator or the Director of Nursing of any medication administration error and will be included in the investigation process through the Quality Assurance Performance Improvement process.	

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F 157	Continued From page 3 Record review of the third Narcotic Count Sheet dated February 20, 2011,(used to record each narcotic dose administered) for liquid morphine for resident #20 revealed a sticker-type label adhered to the top right of the sheet with the following information included: "(resident #20's name); room # (number); MORPHINE SULFATE 100 MG/5 ML (milliliter) substituted for ROXANOL 20 MG/ML SOLUTION; 02/19/11(date); Take 0.05ML-0.1ML (1-2MG) EVERY HOUR AS NEEDED; QTY (quantity) 30 ML.(total dispensed from the pharmacy)" Interview at 10:00 a.m., on May 3, 2011, in the conference room with the Director of Nurses (DON) revealed the following: 1) the narcotic count was incorrect at 3:00 p.m., February 23, 2011, with less liquid narcotic remaining than on the Narcotic Count Sheet record; 2) the DON did not investigate the discrepancy in the narcotic count; 3) the DON changed the amount left to count; 4) on February 23, 2011, the DON interviewed the 11-7 (night shift) Licensed Practical Nurse (LPN #2) and LPN #2 stated the resident had been given 1 ml (20 mg of morphine instead of 2 mg) at 1:00 a.m., 3:00 a.m., and 5 a.m., on February 22, 2011; 5) the DON stated knowledge of the day shift LPN #1 giving two additional 1.0 ml doses of morphine instead of 0.1 ml (20 mg of morphine instead of 2 mg) on February 22, 2011 at 7:00 a.m. and 11:00 a.m. The DON did not define a timeframe for when the DON realized the resident had received a total of five incorrect doses on	F 157	4. Daily monitoring by a Registered Nurse for two weeks, beginning May 5, 2011 through May 19, 2011, then two times a week for three months until August 18, 2011 and/or until 100% compliant, to include a 100% audit of Medication Error Sheets for proper notification of Physician, Administrator, and Director of Nursing; a 100% audit of the Medication Administration Records of residents receiving liquid narcotic doses less than 5 milliliters to ensure compliance of two nurses verifying the dose and signing the Medication Administration Record; and auditing of the alert charting log against the medication error reports to verify alert charting compliance for 72 hours. The Regional Director of Clinical Services will perform a compliance review of 100% of the audit forms and related data weekly until the end of the monitoring time. All audit results will be reported by the Director of Nursing to the monthly Quality Assurance Performance Improvement meetings for review and recommendations. This committee will determine if any revisions are needed to the audit plan.	

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F 157	Continued From page 4 February 22, 2011. Interview confirmed the DON had not considered the irreconcilable narcotic count as a significant medication error and did not notify the physician. Review of the facility's policy 'Medication Error...Reporting' revealed, "Procedures: a. In the event of a significant medication error...immediate action is taken, as necessary, to protect the resident's safety and welfare. b. The attending physician is notified promptly...c. The physician's orders are implemented, and the resident is monitored closely for 24 to 72 hours as directed." Record review of a 'Medication Occurrence Report' revealed the Medical Director was informed of the significant medication error on February 24, 2011. Interview on May 4, 2011, in the conference room with the DON at 8:45 a.m., verified the DON had not followed the facility policy to notify the physician when the significant medication error occurred. Continued interview confirmed on February 22, 2011, in a 10 hour period, resident #20 received 100 mg of morphine instead of the ordered 10 mg and the physician was not notified. The Immediate Jeopardy was effective from February 22, 2011, through May 6, 2011, and was removed on May 6, 2011. An acceptable Allegation of Compliance, which removed the immediacy of the jeopardy, was received and corrective actions were validated on site by the	F 157	The Quality Assurance Performance Improvement Committee consists of Administrator, Medical Director, Director of Nursing, Assistant Director of Nursing, Human Resources, Minimum Data Set Coordinator, Treatment Nurse, Admissions Director, Business Office Manager, Rehab Manager, Medical Records, Social Services, Facilities Management Director, Dietary Manager, and Activity Director. Dietician and Pharmacist reports are reviewed, and these consultants attend as needed.	5/26/11

JUN 03 2011

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F 157	Continued From page 5 survey team on May 6, 2011 through review of facility documents, staff interviews, and observations. The survey team verified the allegation of compliance by: 1.) Verifying one nurse involved in the significant medication error was no longer employed by the facility; and verified the other remaining nurse involved in the significant medication error had been counseled and educated regarding medication administration and had completed return demonstration of medication administration of liquid narcotics on May 6, 2011. The Director of Nursing on site at the start of the survey had resigned without notice on May 4, 2011 and an interim Director of Nursing had been established on May 4, 2011. 2.) Verifying all liquid narcotics records were reviewed by the Regional Director of Clinical Services and a Registered Nurse on May 4, 2011 to confirm accuracy of the Medication Administration Records and the Narcotic Count Sheets to determine if other residents were affected. In addition the surveyors conducted observation of liquid narcotic administration on May 6, 2011. 3.) Verification by the survey team on May 6, 2011 ensured by interviews with the licensed nursing staff and review of in-service logs that the nurses received information regarding the five rights of medication administration; alert charting to be initiated on every shift for seventy-two hours after a medication error; timely notification of the Physician, Director of Nursing and the Administrator after a medication error; and notification of revision of the medication policy	F 157		

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F 157	Continued From page 6 addressing the change of administration of liquid narcotics requiring verification and signatures by two nurses if the amount to be administered is less than 5 milliliters. The survey team verified the facility's Audit Form for Medication Error Notification to begin May 5, 2011 and be conducted daily through May 19, 2011 then decreased to two times weekly for two months through July 19, 2011. Compliance to be conducted by the Regional Director of Clinical Services. 4.) The survey team verified the facility's plan of daily monitoring by a Registered Nurse for a two week duration, beginning May 5, 2011 through May 19, 2011, then two times a week for two months until July 18, 2011 to include a 100 % audit of Medication Error Sheets for proper notification of the Physician, Administrator, and Director of Nursing; a 100 % audit of the Medication Administration Records of residents receiving liquid narcotic doses less than 5 milliliters to ensure compliance of two nurses verifying the dose and signing the Medication Administration Record; and auditing of the alert charting log against the medication error reports to verify alert charting compliance for 72 hours. The survey team verified the facility's plan for the Regional Director of Clinical Services to perform a compliance review of 100% of the audit forms and related data weekly until the end of the monitoring time. The survey team verified the facility's plan to relay results to the Quality Assurance Performance Improvement committee monthly through the end of the monitoring time for review and recommendations. The survey team verified the facility's plan to have the Quality Assurance Performance Improvement committee	F 157		

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F 157	Continued From page 7 determine if any revisions are needed to the audit plan. The survey team verified the facility's plan to have the Quality Assurance Performance Improvement committee consist of, at a minimum, the Administrator, Director of Nursing, Medical Director, and Dietary, Activities, Maintenance, Business office, Social Services, and Pharmacy departments. Non-compliance continues at a "D" level for monitoring of corrective actions. The facility is required to submit a plan of correction. c/o #27994	F 157		
F 165 SS=D	483.10(f)(1) RIGHT TO VOICE GRIEVANCES WITHOUT REPRISAL A resident has a right to voice grievances without discrimination or reprisal. Such grievances include those with respect to treatment which has been furnished as well as that which has not been furnished. This REQUIREMENT is not met as evidenced by: Based on medical record review, interview, and a review of the facility Concern and Comment log, the facility failed to ensure concerns voiced for two (#13, and #26) of thirty-one sampled residents reviewed were investigated. The findings included:	F 165	F165 1. Resident #13 was interviewed on May 19, 2011 by Social Services Director regarding dining experience. Resident #13 expressed no concerns. Resident #13 family was contacted by Social Services Director on May 19, 2011 and expressed no concerns. Resident #26 was interviewed on May 19, 2011 by Social Services Director regarding ADL care. This resident voiced no concerns during interview. Resident #26 family member was contacted by Social Services Director on May 19, 2011 and indicated he has no concerns.	

JUN 0 3 2011

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F 165	Continued From page 8 Resident #13 was re-admitted to the facility on March 25, 2011 with diagnoses to include Cerebral Vascular Accident, Vascular Dementia, Depression, and Anemia. Medical record review of the Minimum Data Set, dated April 8, 2011 revealed the resident required one person assist for meal set-up and limited assist with eating. Review of the facility's Concern and Comment Log, dated August 18, 2010, revealed the resident had reported a concern of not being given enough time to eat. Continued review of the facility's Concern and Comment Log (no date indicated) revealed the Director of Nursing (DON) documented in the investigation section "...Resident has adaptive utensil and eats 100%..." Review of the Concern and Comment Log revealed no documentation the DON has spoken to the resident or investigated the resident's grievance. Resident #26 was admitted to the facility on September 22, 2008, with diagnoses including Cerebralvascular Accident and Hypertension. Medical record review of the resident's nurse's notes, dated April 30, 2011, revealed the resident was alert and oriented and required total assistance for all Activities of Daily Living. Review of the "Concern and Comment" log revealed a concern voiced on July 6, 2010, regarding a family member "finding (the resident) soiled" frequently on visits. Continued review revealed no investigation completed regarding	F 165	2. All residents were interviewed by Social Services Director on 5/17/11 – 5/19/11 regarding any concerns. 3. Social Services Director was inserviced on 5/10/11 by Administrator on Concern and Comment Policy. Resident Council meeting was held on 5/19/11 and the Administrator reviewed the grievance and investigation process. All concerns and comments are reviewed by interdisciplinary team which includes the Administrator, Director of Nursing, Assistant Director of Nursing, Minimum Data Set Coordinator, Medical Records, Social Services, Activity Director, Human Resources, Business Office Manager, Admissions Director, Facilities Management and Dietary Manager Monday through Friday to assure a complete investigation is conducted and an acceptable resolution is found. 4. Beginning 5/26/11 Social Services Director will interview 10 residents and/or family per week for four weeks for concerns and comments, then 10 residents and/or family per month for two months and/or until 100% compliant. All audit results will be reported by the Social Services Director to the monthly Quality Assurance Performance Improvement meetings for review and recommendations. This committee will determine if any revisions are needed to the audit plan.	

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F 165	Continued From page 9 whether the concern was substantiated. Interview with the Administrator and Director of Nursing on May 3, 2011, at 9:00 a.m., in the conference room, confirmed the voiced concerns were not investigated. c/o # 27457	F 165	The Quality Assurance Performance Improvement Committee consists of Administrator, Medical Director, Director of Nursing, Assistant Director of Nursing, Human Resources, Minimum Data Set Coordinator, Treatment Nurse, Admissions Director, Business Office Manager, Rehab Manager, Medical Records, Social Services, Facilities Management Director, Dietary Manager, and Activity Director. Dietician and Pharmacist reports are reviewed, and these consultants attend as needed.	5/26/11
F 248 SS=E	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on review of activity participation logs, medical record review, observation, and interview, the facility failed to ensure a program of activities, in accordance with the comprehensive assessment, was offered to two (#15 and #12) of thirty-one residents reviewed; and the facility failed to ensure attempts were made to engage residents in two of two group activities observed. The findings included: Resident #15 was admitted to the facility on August 30, 2007, with diagnoses including Diabetes and Emphysema.	F 248	**F248** 1. Resident #15 was interviewed on 5/6/11 by the Activity Director regarding her desire to use a broom to sweep her room, her interest in sewing materials and reading materials related to sewing. Resident #15 was interviewed by the Activity Director to determine current interests, and the comprehensive assessment and care plan was updated by Activity Director to reflect these preferences on 5/6/11 -5/24/11. Resident #12 was interviewed by the Activity Director to determine current interests, and the comprehensive assessment and care plan was updated by the Activity Director to reflect these preferences on 5/6/11 – 5/24/11. Activity director inserviced Activity Assistant on 5/18/11 regarding honoring resident preferences and involving and engaging the residents in the activity being conducted.	

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F 248	Continued From page 10 Review of activity participation logs for November/ December 2010 and January 2011 revealed the resident attended multiple activities in November and December but attended only two activities in January. Medical record review of a physician's progress note dated February 24, 2011, revealed the resident stated "nothing to live for" and would "overdose on medications if (the resident) had an opportunity." Medical record review of social services progress notes revealed on February 24, 2011, the resident was admitted to a psychiatric facility and returned on March 4, 2011. Medical record review of social services progress notes, dated May 2, 2011, revealed "(The resident) talks about sewing and how (the resident) enjoys it." Interview with the Activity Assistant (AA) on May 5, 2011, at 9:25 a.m., at the Nurse's Station, revealed the AA was unaware the resident enjoyed sewing, and had not offered any individual sewing related activity to the resident during one-to-one activity visits. Continued interview with the AA revealed the resident had requested a broom to sweep in the resident's room, but the resident was not given a broom due to safety concerns. Continued interview with the AA revealed the resident was not offered a broom under a controlled environment (to address safety concerns) during one-to-one activity visits and confirmed the resident's activity preferences were not honored. Resident #12 was admitted to the facility on April	F 248	2. All residents were interviewed by the Activity Director or the Activity Assistant on 5/6/11 – 5/24/11 for current interests and the comprehensive assessments and care plans were updated by the Activity Director to reflect these preferences. 3. All licensed nurses, Certified Nursing Assistants and Activity Assistant were inserviced by Administrator and Activity Director on 5/6/11 – 5/20/11 to assist residents to any activity they wish to attend. 4. Beginning 5/26/11 Activity Director will audit five group activities per week for four weeks, then 10 group activities per month for two months and/or until 100% compliant. Beginning 5/26/11 Activity Director will interview ten residents a week for four weeks, then 10 residents a month for three months and/or until 100% compliant to ensure current interests are identified. All audit results will be reported by the Activity Director to the monthly Quality Assurance Performance Improvement meetings for review and recommendations. This committee will determine if any revisions are needed to the audit plan.	

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HILLCREST HEALTHCARE SOUTH	1758 HILLWOOD DRIVE KNOXVILLE, TN 37920

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 248	Continued From page 11 23, 2010, with diagnoses including End Stage Renal Disease and Cerebralvascular Accident. Medical record review of the April 30, 2010, Minimum Data Set (MDS), revealed the resident had limitation of movement and partial loss of voluntary movement of arms, hands, legs, and feet on both sides. Continued review of the April 30, 2010, MDS revealed the resident's sitting balance could not be tested without physical help. Medical record review of the April 30, 2010 MDS, "Activity Pursuit Patterns" revealed the resident did not have a preference for exercise as an activity. Observation on May 3, 2011, at 10:45 a.m., revealed the resident in the dining room asleep in a reclined geri chair. Continued observation revealed a video playing on the television explaining the physical movements for Tai Chi (a method of exercise, breathing, and relaxation). Interview with the Activity Director on May 4, 2011, at 4:15 p.m., in the conference room, confirmed the resident did not have the physical capability to participate in Tai Chi, and the comprehensive assessment did not identify exercise as a need or interest for the resident. Observation on May 2, 2011, at 10:00 a.m., revealed several residents in the dining room for the group activity "Current News". Continued observation revealed the activity consisted of the AA reading articles, from the local newspaper, to the residents, including an article on "Forensic Mannequins". Continued observation revealed the AA continually read from the newspaper, with	F 248	The Quality Assurance Performance Improvement Committee consists of Administrator, Medical Director, Director of Nursing, Assistant Director of Nursing, Human Resources, Minimum Data Set Coordinator, Treatment Nurse, Admissions Director, Business Office Manager, Rehab Manager, Medical Records, Social Services, Facilities Management Director, Dietary Manager, and Activity Director. Dietician and Pharmacist reports are reviewed, and these consultants attend as needed.	5/26/11

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F 248	Continued From page 12 no attempts made to involve or engage the residents in the activity. Interview with the Activity Director on May 4, 2011, at 4:20 p.m., in the conference room, confirmed the AA failed to attempt to engage residents in the "Current News" activity; the residents had previously stated a preference for the A.D. to lead the "Current news" activity; and (as observed) the activity was not a meaningful activity for the residents. Observation on May 3, 2011, at 10:45 a.m., revealed the dining room completely full with residents, while a video was playing on the television demonstrating Tai Chi upper body movements to the residents. Continued observation revealed none of the residents were engaged and actually completing the movements described on the video, with fourteen residents noted to either be asleep or with eyes closed. Interview with the Activity Director on May 4, 2011, at 4:25 p.m., in the conference room, confirmed Tai Chi was not a meaningful activity for many of the residents brought to the dining room. c/o # 27457	F 248		
F 281 SS=J	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality.	F 281	F281 1. Resident #20 is no longer at the facility on 2/24/11.	

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F 281	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on facility policy review, review of a Narcotic Count Sheet, medical record review, review of facility documents, review of Standard of Practice for Advanced Trauma Life Support and interview, the facility failed to take appropriate action when 1) significant narcotic medication errors for one resident (#20) occurred and 2) a fall resulting in a fracture with an inappropriate transfer occurred for one resident (#2) of thirty-one residents reviewed. The facility's failure to investigate significant narcotic medication errors and to immediately notify the Administrator, physician, and pharmacist was likely to cause serious injury, harm, impairment or death to resident #20. On May 4, 2011 at 12:05 p.m. in the office of the Administrator, the Administrator and the Corporate Nurse Consultant were informed of the Immediate Jeopardy. The findings included: Resident #20 was admitted to the facility with diagnoses including Diabetes Type II, reoccurring Congestive Heart Failure, Chronic Obstructive Pulmonary Disease/Oxygen-Dependent, Morbid Obesity. Review of the physician's orders for February 2011 revealed on February 19, 2011, an order for Roxanol (a liquid morphine preparation) 1-2 mg (milligrams) PO (by mouth) q 1 (every one) hour	F 281	Resident #2 was transferred to the Emergency Room on 9/5/10 and returned on 914/10. The physician was notified of medication error on 2/24/11 by the Director of Nursing. Administrator educated Director of Nursing on 3/4/11 on the Policies and Procedures for narcotic counts, notification of change, and the incident event management procedure. An investigation was begun on 3/4/11 by the Director of Nursing. The Pharmacy Consultant was notified of the medication error on 3/2/11, and was involved in the investigation of narcotic count error. LPN #2 is no longer employed as of 3/19/11. LPN #1 was unaware of the medication error until 5/4/11. She was counseled and educated on 5/6/11 with return demonstration of administration of liquid narcotics by Director of Nursing. LPN #3 was inserviced on 9/10/10 by the Director of Nursing regarding appropriate assessment of residents after falls. Director of Nursing is no longer employed as of 5/4/11 and an interim Director of Nursing was established on 5/4/11 and was inserviced on the Event Management Policy.	

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F 281	Continued From page 14 PRN (as needed). Record review of the third Narcotic Count Sheet dated February 20, 2011,(used to record the amount of narcotic remaining) for liquid morphine for resident #20 revealed a sticker-type label adhered to the top right of the sheet with the following information included: "(resident #20's name); room#; MORPHINE SULFATE 100 MG/5 ML (milliliters) substituted for ROXANOL 20 MG/ML SOLUTION; 02/19/11(date); Take 0.05ML-0.1ML (1-2MG) EVERY HOUR AS NEEDED; QTY (quantity) 30 ML (total dispensed from the pharmacy)." Continued review of the 'Dose Given' column revealed six LPNs had recorded on the third Narcotic Count Sheet beginning February 20, 2011, at 2:00 p.m., and all had recorded the dose given as 0.1 ml. Review revealed the first four LPNs had subtracted an amount of 0.1 ml from the 'Quantity Remaining' column and the subsequent two LPNs (the nightshift/LPN #2 and the dayshift/LPN #1) had subtracted 1.0 ml from the total liquid remaining when administering the liquid MSO4 narcotic from 1:00 a.m., on February 22, 2011, through 11:00 a.m., on February 22, 2011; the entries were as follows: "...2-21-11 9 pm 0.1 mL (dose given) 28.3 mL (quantity remaining)...2-21-11 10 pm 0.1 mL (dose given) 28.2 mL (quantity remaining)...2-21-11 11 pm 0.1 mL (dose given) 28.1 mL (quantity remaining)...2-22-11 1 am 0.1 mL (dose given) 27.1 mL (quantity remaining)...2-22-11 3 am 0.1 mL (dose given) 26.1 mL (quantity remaining)...2-22-11 5 am 0.1 mL (dose given) 25.1 mL (quantity remaining)...2-22-11 7 am 0.1 mL (dose given) 24.1 mL (quantity	F 281	2. An audit of 100% of the liquid narcotic medication sheets was done by the Director of Nursing on 3/4/11. No other residents were identified as being affected. All liquid narcotics records were reviewed by the Regional Director of Clinical Services and a Registered Nurse on 5/4/11. No other residents were found to be affected. All incidents with falls will be audited for proper assessment technique after a fall by Director of Nursing or Assistant Director of Nursing for two weeks, then three times a week for three months and/or 100% compliant. Beginning 5/25/11 Resident Event Reports involving falls will be audited daily by the Director of Nursing, Assistant Director of Nursing or nursing supervisor for two weeks, then three times a week for three months and/or 100% compliance to assure falls protocol for proper assessment technique is followed. 3. Inservice was given to all licensed nursing staff by Director of Nursing on 3/4/11 – 3/10/11 regarding measuring narcotic liquids with return demonstration required.	

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F 281	Continued From page 15 remaining)...2-22-11 11 am 0.1 mL (dose given) 23.1 mL (quantity remaining)..." Continued record review of the third Narcotic Count Sheet for resident #20 revealed a discrepancy in the amount 'left to count' on February 22, 2011. Review of the Narcotic Count Sheet revealed Licensed Practical Nurse (LPN#1) administered a dose of MSO4 on February 22, 2011 at 11:00 a.m., and recorded 23.1 ml in the column 'Quantity Remaining.' Continued review revealed a line marked through the 23.1 total remaining and 20 ml written and signed by the Director of Nurses (DON). Interview in the conference room, with the DON, on May 3, 2011, at 10:00 a.m., revealed the DON stated the morphine liquid left in the bottle did not match the amount of 23.1 ml 'Quantity Remaining' on the Narcotic Count Sheet during the 3:00 p.m. shift change count on February 22, 2011. Continued interview revealed the oncoming evening shift LPN #7 stated the amount remaining was not accurate if the total amount given from the time the LPN had left at 11:00 p.m., the evening of February 21, 2011 to the present was 0.1 ml with each subsequent five doses. Continued interview revealed the DON did no further questioning about the amount remaining to be 20 ml (equal to 40 milligrams of narcotic medication), and recorded 20 ml remained. Continued interview confirmed the DON had signed the Narcotic Count Sheet in the column to the left of 'Quantity Remaining', wrote in 20 ml, and took no further action until February 23, 2011. During interview, the DON stated on	F 281	Facility policy on Administering Controlled Medications was revised by Administrator and Director of Nursing on 5/4/11 to require that two nurses verify and sign off on the Medication Administration Record all liquid narcotic doses less than 5ml. On 5/6/11 this revision was added to the narcotic med pass policy and Med Pass Observation sheet by the Regional Director of Clinical Services and signed by the Administrator and Director of Nursing. All licensed nurses were educated by Regional Director of Clinical Services, Director of Nursing and Admissions Nurse on 5/4/11 – 5/20/11 on the following requirements: verification of any liquid narcotic less than 5 mls by a second nurse who must also initial Medication Administration Record. Inservices also included the Five Rights of Medication Administration, alert charting to be initiated on every shift for seventy-two hours after a medication error, timely notification of the Physician, Director of Nursing and the Administrator after a medication error. The Medical Director and Pharmacy Consultant will be advised by the Administrator or the Director of Nursing of any medication administration error and will be included in the investigation process through the Quality Assurance Performance Improvement process. Director of Nursing inserviced licensed nurses on 9/7/10 on proper assessment of residents after falls.	

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F 281	Continued From page 16 the morning of February 23, 2011, the night shift nurse, LPN #2, was questioned by the DON and revealed the resident had been given a 1 ml dose of morphine (20 mg instead of 2 mg ordered) at 1:00 a.m., 3:00 a.m., and 5:00 a.m., by LPN #2 on February 22, 2011. During interview, the DON stated he/she did not realize the two doses given by LPN #1 on February 22, 2011, at 7:00 a.m., and 11:00 a.m., had also been 1 ml each (20 mg instead of 2 mg ordered) until "later." Review of the facility's policy 'Medication Error ...Reporting' revealed, "Procedures: a. In the event of a significant medication error ...immediate action is taken, as necessary, to protect the resident's safety and welfare. b. The attending physician is notified promptly ...c. The physician's orders are implemented, and the resident is monitored closely for 24 to 72 hours as directed." Review of the 'Controlled Medication Storage' policy and procedures revealed, "...e. Any discrepancy in controlled substance medication counts is reported to the director of nursing immediately. The director...makes every reasonable effort to reconcile all reported discrepancies. Irreconcilable discrepancies are documented by the director of nursing in a report to the administrator. If a major discrepancy...occurs...the director of nursing notifies the administrator and consultant pharmacist immediately..." Interview with the DON at 8:45 a.m., on May 4, 2011, in the conference room confirmed the DON had not followed the facility policy for reconciliation of a controlled medication; had not	F 281	All licensed nurses were inserviced on 5/17/11 – 520/11 by Regional Director of Clinical Services and Director of Nursing on proper assessment of residents after falls. 4. Daily monitoring by a Registered Nurse for two weeks, beginning May 5, 2011 through May 19, 2011, then two times a week for three months until August 18, 2011 and/or until 100% compliant, to include a 100% audit of Medication Error Sheets for proper notification of Physician, Administrator, and Director of Nursing; a 100% audit of the Medication Administration Records of residents receiving liquid narcotic doses less than 5 milliliters to ensure compliance of two nurses verifying the dose and signing the Medication Administration Record; and auditing of the alert charting log against the medication error reports to verify alert charting compliance for 72 hours. The Regional Director of Clinical Services will perform a compliance review of 100% of the audit forms and related data weekly until the end of the monitoring time.	

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F 281	Continued From page 17 followed facility policy when the significant medication error occurred; had not investigated the 7.5 ml (equaling 150 mg) of morphine not accounted for on February 22, 2011; and had not notify the administrator, physician, and consultant pharmacist "immediately." Resident #2 was admitted to the facility on April 30, 2008, with diagnoses including Chronic Obstructive Pulmonary Disease and Intracranial Hemorrhage. Medical record review of the July 15, 2010, Minimum Data Set (MDS), revealed the resident had a history of falls in the past 30 days and 180 days. Medical record review of physical therapy progress notes, dated July 15, 2010, revealed the resident was safe to transfer independently, and was referred to the restorative program. Medical record review of nurse's notes, dated September 5, 2010, revealed "Sitting in BR (bathroom) floor with pants down states, 'I lost my balance'-c/o (complains of) pain R (right) hip-can move all exts (extremities) except for R (right) LE (lower extremity)-assisted to w/c (wheelchair) -resident vomited x (times) 1 lg (large) amt (amount) white frothy-face red, shaking, R leg 1/2 in (inch) shorter than L (left)..." Continued medical record review of nurse's notes revealed the resident was subsequently transferred to the emergency room with the diagnosis of right hip fracture. Review of facility documents revealed a nursing department inservice was held on September 7, 2010, at 3:00 p.m. "Should a fall occur-Resident should not be moved until: ROM (range of	F 281	All audit results will be reported by the Director of Nursing to the monthly Quality Assurance Performance Improvement meetings for review and recommendations. This committee will determine if any revisions are needed to the audit plan. The Quality Assurance Performance Improvement Committee consists of Administrator, Medical Director, Director of Nursing, Assistant Director of Nursing, Human Resources, Minimum Data Set Coordinator, Treatment Nurse, Admissions Director, Business Office Manager, Rehab Manager, Medical Records, Social Services, Facilities Management Director, Dietary Manager, and Activity Director. Dietician and Pharmacist reports are reviewed, and these consultants attend as needed.	5/26/11

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 281	Continued From page 18 motion); assess for pain/injury; neur (neurological) checks if head injury...should resident be unable to completed (complete) ROM, c/o (complain) of pain/injury or display evidence of fx (fracture)-Do Not Move...make resident comfortable where they are with pillow/blankets and notify M.D. (physician) and EMS (emergency medical services), as needed." Continued review of facility documents revealed on September 9, 2010, LPN #3 received a "corrective action" because the LPN moved the resident after the resident exhibited signs/symptoms of a possible fracture. Interview with the Director of Nursing on May 3, 2011, at 4:45 p.m., in the conference room, confirmed LPN #3 moved the resident from a lying to a sitting position (into the wheelchair), after LPN #3 assessed the resident's inability to move the lower right extremity, and the resident's right leg being "1/2 inch shorter than the left". Continued interview with the Director of Nursing confirmed moving the resident was not in accordance with acceptable standards of practice. Standard of practice for Advanced Trauma Life Support requires "...the development of the advanced trauma life support (ATLS) approach by the American College of Surgeons. ATLS is the standard of care for trauma patients, and it is built around a standardized protocol for patient evaluation. This protocol ensures that the most immediate life-threatening conditions are actively identified and addressed in the order of their risk potential. The objectives of the initial evaluation of the trauma patient are as follows: (1) to	F 281		

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F 281	Continued From page 19 stabilize the trauma patient, (2) to identify life-threatening injuries and to initiate adequate supportive therapy, and (3) to efficiently and rapidly organize either definitive therapy or transfer to a facility that provides definitive therapy..." The Immediate Jeopardy was effective from February 22, 2011, through May 6, 2011, and was removed on May 6, 2011. An acceptable Allegation of Compliance, which removed the immediacy of the jeopardy, was received and corrective actions were validated by the survey team through review of facility documents, staff interviews, and observations conducted onsite on May 6, 2011. The survey team verified the allegation of compliance by: 1.) Verifying one nurse involved in the significant medication error was no longer employed by the facility; and verified the other remaining nurse involved in the significant medication error had been counseled and educated regarding medication administration and had completed return demonstration of medication administration of liquid narcotics on May 6, 2011. The Director of Nursing on site at the start of the survey had resigned without notice on May 4, 2011 and an interim Director of Nursing had been established on May 4, 2011. 2.) Verifying all liquid narcotics records were reviewed by the Regional Director of Clinical Services and a Registered Nurse on May 4, 2011 to confirm accuracy of the Medication Administration Records and the Narcotic Count Sheets to determine if other residents were	F 281		

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F 281	Continued From page 20 affected. In addition the surveyors conducted observation of liquid narcotic administration on May 6, 2011. 3.) Verification by the survey team on May 6, 2011 ensured by interviews with the licensed nursing staff and review of in-service logs that the nurses received information regarding the five rights of medication administration; alert charting to be initiated on every shift for seventy-two hours after a medication error; timely notification of the Physician, Director of Nursing and the Administrator after a medication error; and notification of revision of the medication policy addressing the change of administration of liquid narcotics requiring verification and signatures by two nurses if the amount to be administered is less than 5 milliliters. The survey team verified the facility's Audit Form for Medication Error Notification to begin May 5, 2011 and be conducted daily through May 19, 2011 then decreased to two times weekly for two months through July 19, 2011. Compliance to be conducted by the Regional Director of Clinical Services. 4.) The survey team verified the facility's plan of daily monitoring by a Registered Nurse for a two week duration, beginning May 5, 2011 through May 19, 2011, then two times a week for two months until July 18, 2011 to include a 100 % audit of Medication Error Sheets for proper notification of the Physician, Administrator, and Director of Nursing; a 100 % audit of the Medication Administration Records of residents receiving liquid narcotic doses less than 5 milliliters to ensure compliance of two nurses	F 281		

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F 281	Continued From page 21 verifying the dose and signing the Medication Administration Record; and auditing of the alert charting log against the medication error reports to verify alert charting compliance for 72 hours. The survey team verified the facility's plan for the Regional Director of Clinical Services to perform a compliance review of 100% of the audit forms and related data weekly until the end of the monitoring time. The survey team verified the facility's plan to relay results to the Quality Assurance Performance Improvement committee monthly through the end of the monitoring time for review and recommendations. The survey team verified the facility's plan to have the Quality Assurance Performance Improvement committee determine if any revisions are needed to the audit plan. The survey team verified the facility's plan to have the Quality Assurance Performance Improvement committee consist of, at a minimum, the Administrator, Director of Nursing, Medical Director, and Dietary, Activities, Maintenance, Business office, Social Services, and Pharmacy departments. Non-compliance continues at a "D" level for monitoring of corrective actions. The facility is required to submit a plan of correction. c/o # 27457 c/o #27994	F 281		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident	F 314	F314 1. Treatment Nurse assessed Resident #8's heels, performed treatment and floated the heels and no adverse outcomes identified on 5/4/11.	

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F 314	Continued From page 22 who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of wound tracking reports, facility policy review, observation, and interview the facility failed to prevent pressure ulcers from developing for two residents (#8 and #23) of thirty-one residents reviewed. The facility's failure to consistently implement measures to prevent the development of pressure sores resulted in harm to residents #8 and #23, who developed pressure sores. The findings included: Resident #8 was admitted on February 19, 2010, with diagnoses including Failure to Thrive, Malaise, Fatigue, and Alzheimer's Dementia with Psychosis and Anxiety. Medical record review of the Quarterly Minimum Data Set (MDS) dated November 16, 2010, and the Annual MDS dated February 16, 2011, revealed the resident did not have a history of pressure ulcer and did not have any pressure ulcer at the time of the assessments. Review revealed the Annual MDS stated the resident required extensive assist of one person for bed mobility.	F 314	Resident #8 wound was evaluated by physician and new orders noted on 5/6/11. Resident #8 Pressure Sore Risk Assessment and Pressure Ulcer checklist were completed and care plan updated on 5/18/11 by Treatment Nurse. Resident #23 was assessed and treatment performed by the Treatment Nurse on 5/4/11 and no adverse outcomes identified. Resident #23 wound was evaluated by the physician and new orders noted on 5/6/11. Resident #23 Pressure Sore Risk Assessment and Pressure Ulcer checklist were completed and care plan updated on 5/18/11 by Treatment Nurse. Treatment Nurse was inserviced on 5/6/11 on proper staging and wound treatments by Regional Director of Clinical Services. 2. An assessment was completed by physician on 5/6/11 on all residents with in-house acquired pressure ulcers and new orders were written as appropriate. A team consisting of Treatment Nurse, Regional Director of Clinical Services, and Treatment Nurse Consultant performed wound assessments on all residents with current wounds, both in house acquired and admitted with, on 5/11/11 and evaluated wound treatments and updated wound treatments per physician order.	

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	445476	A. BUILDING _____ B. WING _____	05/06/2011

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F 314	Continued From page 23 Medical record review of the 'Braden Scale-For Predicting Pressure Sore Risk' assessed the resident on February 24, 2011 with a score of 13, indicating a 'moderate risk' for pressure sore development. Record review of the resident's care plan dated December 3, 2010, included the problems, "Self care deficit secondary to Dementia, needs extensive assistance" and "Risk for skin breakdown r/t (related to) inc' (incontinent) B/B (bladder and bowel)...Goal - Maintain intact skin integrity by next review 5/16/11..." Review of the care plan revealed handwritten additions dated April 11, 2011, "Blister...L (left) heel...will show s/s (signs and symptoms) of healing, will not show s/s of infection by 5/20/11...wound care treatment as ordered ...float heels." Record review of the progress note from the consulting psychiatric nurse practitioner on March 9, 2011, revealed, "...long h/o (history of) depression, delusions, agitation...No increase in behavior symptoms...Lying in bed today...Will try increase in Remeron (an anti-depressant medication also used as a hypnotic and appetite stimulant)..." Review of the next progress note from the consulting psychiatric nurse practitioner on April 13, 2011, revealed, "...More somnolent and lethargic. Always in bed...is lying in bed today. " Medical record review of the physician's orders for April 13, 2011 included an order from the psychiatric nurse practitioner to decrease the Risperdal (an anti-psychotic) to 0.5 mg (milligrams) every hs (bedtime) for 7 days and then discontinue.	F 314	Assistant Director of Nursing and Treatment Nurse completed head to toe skin assessments on all residents on 5/18/11. Pressure Sore Risk Assessments and Pressure Ulcer Prevention Checklists as indicated were completed on 5/18/11 – 5/25/11 on all residents and care plans updated by Assistant Director of Nursing and Treatment Nurse. 3. Licensed nurses and Certified Nurse Assistants were inserviced by Treatment Nurse on 5/5/11 – 5/24/11 on assuring residents' heels are floated per care plan and treatment interventions. Nursing staff on any type of leave will be inserviced prior to performing patient care upon return. 4. Beginning 5/26/11 Treatment Nurse and/or Supervisor will audit 20 residents a week for four weeks then 20 residents per month for three months and/or 100% compliance for accuracy of weekly skin assessments and floating heels as indicated by care plan and treatment interventions and completion by licensed nurse. Beginning 5/26/11 Assistant Director of Nursing or Director of Nursing will audit all in-house wounds weekly for three months and/or 100% compliance to assure proper staging and treatment.	

CNA's have care sheets with interventions

JUN 03 2011

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F 314	Continued From page 24 Observations at 6:30 a.m., and 1:00 p.m., on May 2, 2011, revealed the resident lying in bed with the left foot resting on the mattress. Observation at 8:50 a.m., on May 3, 2011, revealed the resident lying in bed, being fed by a certified nursing assistant (CNA) with the left foot resting on the mattress. Interview in the conference room, with Licensed Practical Nurse (LPN #4) on May 5, 2011, at 4:00 p.m., verified the facility used pillows for floating the residents' heels off of the bed and this was frequently ineffective due to the residents (including resident #8) kicking the pillows out from under their feet and legs. Medical record review of the 'Weekly Skin Integrity Assessment' from the week of March 23, 2011 through April 20, 2011, revealed each week, including April 6, 2011, the assessment stated resident #8's skin integrity was intact. Interview on May 3, 2011, at 3:30 p.m., at the nursing station, with LPN #6 (responsible for the April 6, 2011, skin assessment) revealed, "...hard to assess...doesn't want to be bothered...I missed it (referring to the left heel blister)" Review of the "INHOUSE" PRESSURE Wound Tracking Report revealed on April 6, 2011, resident #8 had a left heel blister as follows: "Presenting-Stage 2, Size (cm/centimeters)-0.7 x 2.1, Progress-New." Review of the Wound Tracking Report dated April 27, 2011, revealed the pressure ulcer remained a Stage 2 with the size in cms "0.6 x 0.4 with 0 depth."	F 314	Pressure Sore Risk Assessment and Pressure Ulcer Prevention Checklist if indicated will be audited on all new admission assessments, quarterly assessments, and significant change assessments for accuracy by Treatment Nurse, Assistant Director of Nursing or Director of Nursing for one month, then 20 assessments per month for two months and/or 100% compliance is attained. All audit results will be reported by the Director of Nursing to the monthly Quality Assurance Performance Improvement meetings for review and recommendations. This committee will determine if any revisions are needed to the audit plan. The Quality Assurance Performance Improvement Committee consists of Administrator, Medical Director, Director of Nursing, Assistant Director of Nursing, Human Resources, MDS, Treatment Nurse, Admissions Director, Business Office Manager, Rehab Manager, Medical Records, Social Services, Facilities Management Director, Dietary Manager, and Activity Director. Dietician and Pharmacist reports are reviewed, and these consultants attend as needed.	5/26/11

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F 314	Continued From page 25 Medical record review of the Dietary Progress Notes of April 15, 2011, revealed the first entry by the registered dietician (RD), nine days after the left heel pressure ulcer was identified, as follows: "...April wt (weight) 164# (pounds). Usual wt ~ (approximately) 165-175# over past year...Eating 52% (percent) average per 7 day review...whole milk TID (three times a day)...house supplement TID...Needs an additional 15 gm (grams) protein/day...Increased nutrition needs to promote healing... " During interview, with the RD in the conference room on May 4, 2011, at 10:50 a.m., the RD stated, "(resident) was eating well by the time the pressure ulcer developed." Interview and observation on May 4, 2011, at 10:00 a.m., in the resident's room with the Wound Care Nurse, revealed the pressure ulcer was observed as the same size and stage as measured on April 27, 2011. During observation, the Wound Care Nurse verified the left foot of the resident was dry with flaking dead skin and confirmed the left heel ulcer had occurred due to pressure. Resident #23 was admitted to the facility on September 16, 2008, and re-admitted to the facility December 9, 2010, with diagnoses including Vascular Dementia, Encephalopathy, Deficiency Anemia, Diabetes Mellitus, Renal Failure, and Chronic Kidney Disease. Medical record review of the Minimum Data Set dated January 20 and March 18, 2011, revealed the resident had impaired memory, severely impaired cognition, was dependent on staff for	F 314		

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F 314	Continued From page 26 activities of daily living, and had no pressure ulcers. Medical record review of the Nursing Admission Assessment Pressure Sore Assessment dated December 10, 2010, revealed "...Is resident at risk of developing pressure ulcer...Yes...Total Score for Skin Risk Part One: Lower score indicates higher risk...(resident scored 14)...13 to 14 = Moderate Risk...Pressure Sore Risk Assessment Part 2...Total Score for Pressure Ulcer Risk Assessment Part 2. 14. Review the scores for Part 1 and Part 2 of the Pressure Ulcer Risk Assessment. If the score for Part 1 is 14 or below or the score for Part 2 is 8 or above complete the Pressure Ulcer Prevention Check List and implement care plan for treatment or prevention..." Continued review of the Pressure Sore Assessment revealed it was marked as Pressure Ulcer Prevention Checklist being completed, but no checklist had been completed. Continued review of the Pressure Sore Risk assessment revealed the resident had severe edema (swelling) and had at least three or more predisposing diseases for pressure ulcer development (Renal Disease, Anemia, and Diabetes Mellitus). Medical record review of the Care Plan dated January 25, 2011, revealed the resident was identified as "Risk for skin breakdown, hx (history) blisters..." with interventions implemented to prevent pressure ulcers including "...Float Heels..." Medical record review of the physician progress notes for March and April, 2011, revealed the resident was receiving steroid therapy (side	F 314		

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F 314	Continued From page 27 effects include elevated blood glucose levels and poor wound healing), had been experiencing poor blood glucose control with very high levels, and the physician was adjusting insulin dosages to control the Diabetes. Medical record review of the Wound Tracking Report revealed the resident was noted to have a blister to the left heel on April 12, 2011, noted as a stage 2 pressure ulcer, and treatment was implemented. Continued review of the Wound Tracking Report revealed April 20, 2011, the wound was a stage 2 pressure ulcer, 2.3 cm (centimeters) by 3.2 cm, described as a blister, and improving. Continued review of the Wound Tracking Report revealed April 27, 2011, the wound was a stage 2 pressure ulcer, 1.8 cm by 3.4 cm, described as a blister, and improving. Medical record review of the Departmental Notes revealed the following notes: "April 12, 2011, 4:40 AM...Change of Status. Left heel with new tx (treatment) orders noted and started - heels floated...April 13, 2011, 1:23 PM...Tx nurse continues care for left heel, shoes left off all times, heels floated in bed...April 27, 2011, 12:38 PM...Treatment continues to L (left) heel ulcer. Wound bed is approximately 20% black eschar (area of dead tissue), with the remaining wound bed granulating and clean. No odor is noted and small amount of yellowish drainage noted on removed bandage. +2 pitting edema noted in bed, pedal pulse difficult to feel but is present...will continue to float heels while in bed..." Interview with the Treatment Nurse and observation of the left heel on May 4, 2011, from	F 314		

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F 314	Continued From page 28 1:50 p.m., until 2:05 p.m., in the resident's room, revealed the wound first appeared as a blood-filled blister, measured 3.4 cm by 3.6 cm with an area of eschar approximately 2 cm by 2.5 cm, and the Treatment Nurse called the wound a Stage 2 pressure ulcer. Review of the facility's Treatment of Pressure Sores, Chapter 2 (no policy number or date) revealed, "...To stage a pressure ulcer, you must be able to see the base of the wound. Therefore, you cannot stage pressure ulcers that are covered with necrotic tissue until the eschar is debrided and the base of the wound is visible (NPUAP [National Pressure Ulcer Advisory Panel], 2007). Until debridement can be done, document that the ulcer is unstageable..." Interview with the Treatment Nurse and observation of the resident on May 4, 2011, at 5:10 p.m., in the resident's room, confirmed the resident was in bed with the lower legs placed on top of one folded pillow, and both heels were pressing into the mattress. Continued observation and interview confirmed, when the blister appeared, the resident had been wearing approved diabetic shoes, which were now in the resident's closet and no longer worn by the resident. Continued observation and interview confirmed the treatment nurse obtained more pillows and utilized three pillows to float the resident's heels off the mattress. Medical record review and interview with the Treatment Nurse on May 4, 2011, at 4:50 p.m., 5:00 p.m., and 5:20 p.m., at the nursing station, and at 5:10 p.m., in the resident's room, confirmed the nurse had not documented when	F 314		

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F 314	Continued From page 29 the blister had "burst." Further medical record review and interview confirmed the wound had inaccurately been described as a blister on the Wound Tracking Report April 20 and 27, 2011; the wound was inaccurately described as a Stage 2, when eschar was present; the Pressure Ulcer Prevention Checklist had not been completed on December 10, 2010, when the resident was identified as a high risk for development of pressure ulcers; and the resident's heels had not been floated off the mattress as required by the care plan and treatment interventions.	F 314		
F 333 SS=J	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on facility policy review, review of a Narcotic Count Sheet, medical record review, observation, and interview, the facility failed to ensure one resident (#20) was free of significant medication errors of thirty-one residents reviewed. The facility's failure to ensure residents were free of significant medication errors was likely to cause serious injury, harm, impairment, or death to resident #20. On May 4, 2011 at 12:05 p.m., in the office of the Administrator, the Administrator and the Corporate Nurse Consultant were informed of the Immediate Jeopardy.	F 333	F333 1. Resident #20 is no longer at the facility on 2/24/11. The physician was notified of medication error on 2/24/11 by the Director of Nursing. Administrator educated Director of Nursing on 3/4/11 on the Policies and Procedures for narcotic counts, notification of change, and the incident event management procedure. An investigation was begun by the Director of Nursing on 3/4/11. The Pharmacy Consultant was notified of the medication error on 3/2/11, and was involved in the investigation of narcotic count error.	

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F 333	Continued From page 30 The findings included: Resident #20 was admitted to the facility with diagnoses including Diabetes Type II, reoccurring Congestive Heart Failure, Chronic Obstructive Pulmonary Disease/Oxygen-Dependent, Morbid Obesity; Chronic Anemia related to slow Gastro-Intestinal Bleeding requiring intermittent blood transfusions, Dementia with Depression, and Liver Failure with Blood Disorder diagnosed in December 2010. Review of the nurse's progress notes for February 19, 2011, at 10:15 a.m., revealed, " ...Spoke with (names of two sons). Total comfort care agreed. No hospitalization. New order for MSO4 (morphine, a narcotic) and Atropine (decreases secretions)...Will monitor." Review of the physician's orders for February 2011 revealed on February 19, 2011, an order for Roxanol (a liquid morphine preparation) 1-2 mg (milligrams) PO (by mouth) q 1 (every one) hour PRN (as needed). Record review of the third Narcotic Count Sheet dated February 20, 2011,(used to record the amount of narcotic remaining) for liquid morphine for resident #20 revealed a sticker-type label adhered to the top right of the sheet with the following information included: "(resident #20's name); room# (number); MORPHINE SULFATE 100 MG/5 ML (milliliters) substituted for ROXANOL 20 MG/ML SOLUTION; 02/19/11(date); Take 0.05ML-0.1ML (1-2MG) EVERY HOUR AS NEEDED; QTY (quantity) 30 ML (total dispensed from the pharmacy)."	F 333	LPN #2 is no longer employed as of 3/19/11. LPN #1 was unaware of the medication error until 5/4/11. She was counseled and educated on 5/6/11 with return demonstration of administration of liquid narcotics by Director of Nursing. 2. An audit of 100% of the liquid narcotic medication sheets was done by the Director of Nursing on 3/4/11. No other residents were identified as being affected. All liquid narcotics records were reviewed by the Regional Director of Clinical Services and a Registered Nurse on 5/4/11. No other residents were found to be affected. 3. Inservice was given to all licensed nursing staff by Director of Nursing on 3/4/11 – 3/10/11 regarding measuring narcotic liquids with return demonstration required. Facility policy on Administering Controlled Medications was revised by Administrator and Director of Nursing on 5/4/11 to require, that two nurses verify and sign off on the Medication Administration Record all liquid narcotic doses less than 5ml. On 5/6/11 this revision was added to the narcotic med pass policy and Med Pass Observation sheet by the Regional Director of Clinical Services and signed by the Administrator and Director of Nursing.	

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F 333	Continued From page 31 Continued review of the 'Dose Given' column revealed six LPNs had recorded on the third Narcotic Count Sheet beginning February 20, 2011, at 2:00 p.m., and all had recorded the dose given as 0.1 ml. Review revealed the first four LPNs had subtracted an amount of 0.1 ml from the 'Quantity Remaining' column and the subsequent two LPNs (the nightshift/LPN #2 and the dayshift/LPN #1) had subtracted 1.0 ml from the total liquid remaining when administering the liquid MSO4 narcotic from 1:00 a.m., on February 22, 2011, through 11:00 a.m., on February 22, 2011; the entries were as follows: "...2-21-11 9 pm 0.1 mL (dose given) 28.3 mL (quantity remaining)...2-21-11 10 pm 0.1 mL (dose given) 28.2 mL (quantity remaining)...2-21-11 11 pm 0.1 mL (dose given) 28.1 mL (quantity remaining)...2-22-11 1 am 0.1 mL (dose given) 27.1 mL (quantity remaining)...2-22-11 3 am 0.1 mL (dose given) 26.1 mL (quantity remaining)...2-22-11 5 am 0.1 mL (dose given) 25.1 mL (quantity remaining)...2-22-11 7 am 0.1 mL (dose given) 24.1 mL (quantity remaining)...,2-22-11 11 am 0.1 mL (dose given) 23.1 mL (quantity remaining)..." Continued record review of the third Narcotic Count Sheet for resident #20 revealed a discrepancy in the amount 'left to count' on February 22, 2011. Review of the Narcotic Count Sheet revealed Licensed Practical Nurse (LPN#1) administered a dose of MSO4 on February 22, 2011 at 11:00 a.m., and recorded 23.1 ml in the column 'Quantity Remaining.' Continued review revealed a line marked through the 23.1 total remaining and 20 ml written and signed by the Director of Nurses (DON).	F 333	All licensed nurses were educated by Regional Director of Clinical Services, Director of Nursing and Admissions Nurse on 5/4/11 – 5/20/11 on the following requirements: verification of any liquid narcotic less than 5 mls by a second nurse who must also initial Medication Administration Record. Inserves also included the Five Rights of Medication Administration, alert charting to be initiated on every shift for seventy-two hours after a medication error, timely notification of the Physician, Director of Nursing and the Administrator after a medication error. The Medical Director and Pharmacy Consultant will be advised by the Administrator or the Director of Nursing of any medication administration error and will be included in the investigation process through the Quality Assurance Performance Improvement process. 4. Daily monitoring by a Registered Nurse for two weeks, beginning May 5, 2011 through May 19, 2011, then two times a week for three months until August 18, 2011 and/or until 100% compliant, to include a 100% audit of Medication Error Sheets for proper notification of Physician, Administrator, and Director of Nursing; a 100% audit of the Medication Administration Records of residents receiving liquid narcotic doses less than 5 milliliters to ensure compliance of two nurses verifying the dose and signing the Medication Administration Record; and auditing of the alert charting log against the medication error reports to verify alert charting compliance for 72 hours.	

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F 333	Continued From page 31 Continued review of the 'Dose Given' column revealed six LPNs had recorded on the third Narcotic Count Sheet beginning February 20, 2011, at 2:00 p.m., and all had recorded the dose given as 0.1 ml. Review revealed the first four LPNs had subtracted an amount of 0.1 ml from the 'Quantity Remaining' column and the subsequent two LPNs (the nightshift/LPN #2 and the dayshift/LPN #1) had subtracted 1.0 ml from the total liquid remaining when administering the liquid MSO4 narcotic from 1:00 a.m., on February 22, 2011, through 11:00 a.m., on February 22, 2011; the entries were as follows: "...2-21-11 9 pm 0.1 mL (dose given) 28.3 mL (quantity remaining)...2-21-11 10 pm 0.1 mL (dose given) 28.2 mL (quantity remaining)...2-21-11 11 pm 0.1 mL (dose given) 28.1 mL (quantity remaining)...2-22-11 1 am 0.1 mL (dose given) 27.1 mL (quantity remaining)...2-22-11 3 am 0.1 mL (dose given) 26.1 mL (quantity remaining)...2-22-11 5 am 0.1 mL (dose given) 25.1 mL (quantity remaining)...2-22-11 7 am 0.1 mL (dose given) 24.1 mL (quantity remaining)...2-22-11 11 am 0.1 mL (dose given) 23.1 mL (quantity remaining)..." Continued record review of the third Narcotic Count Sheet for resident #20 revealed a discrepancy in the amount 'left to count' on February 22, 2011. Review of the Narcotic Count Sheet revealed Licensed Practical Nurse (LPN#1) administered a dose of MSO4 on February 22, 2011 at 11:00 a.m., and recorded 23.1 ml in the column 'Quantity Remaining.' Continued review revealed a line marked through the 23.1 total remaining and 20 ml written and signed by the Director of Nurses (DON).	F 333	repeated repeated Facility policy on Administering Controlled Medications was revised by Administrator and Director of Nursing on 5/4/11 to require that two nurses verify and sign off on the Medication Administration Record all liquid narcotic doses less than 5ml. On 5/6/11 this revision was added to the narcotic med pass policy and Med Pass Observation sheet by the Regional Director of Clinical Services and signed by the Administrator and Director of Nursing. All licensed nurses were educated by Regional Director of Clinical Services, Director of Nursing and Admissions Nurse on 5/4/11 – 5/20/11 on the following requirements: verification of any liquid narcotic less than 5 mls by a second nurse who must also initial Medication Administration Record. Inservices also included the Five Rights of Medication Administration, alert charting to be initiated on every shift for seventy-two hours after a medication error, timely notification of the Physician, Director of Nursing and the Administrator after a medication error.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 333	Continued From page 32 Interview in the conference room, with the DON, on May 3, 2011, at 10:00 a.m., revealed the DON stated the morphine liquid left in the bottle did not match the amount of 23.1 ml 'Quantity Remaining' on the Narcotic Count Sheet during the 3:00 p.m. shift change count on February 22, 2011. Continued interview revealed the oncoming evening shift LPN #7 stated the amount remaining was not accurate if the total amount given from the time the LPN had left at 11:00 p.m., the evening of February 21, 2011 to the present was 0.1 ml with each subsequent five doses. Interview revealed the DON did no further questioning about the amount remaining, judged the amount remaining to be 20 ml (equal to 40 milligrams of narcotic medication), and recorded 20 ml remained. Interview confirmed the DON had signed the Narcotic Count Sheet in the column to the left of 'Quantity Remaining', wrote in 20 ml, and took no further action until February 23, 2011. During interview, the DON stated on the morning of February 23, 2011, the night shift nurse, LPN #2, was questioned by the DON and revealed the resident had been given a 1 ml dose of morphine (20 mg instead of 2 mg ordered) at 1:00 a.m., 3:00 a.m., and 5:00 a.m., by LPN #2 on February 22, 2011. During interview, the DON stated he/she did not realize the two doses given by LPN #1 on February 22, 2011 at 7:00 a.m. and 11:00 a.m. had also been 1 ml each (20 mg instead of 2 mg ordered) until "later." Review of the facility's policy 'Medication Error ...Reporting' revealed, "Procedures: a. In the event of a significant medication error ...immediate action is taken, as necessary, to	F 333	The Regional Director of Clinical Services will perform a compliance review of 100% of the audit forms and related data weekly until the end of the monitoring time. All audit results will be reported by the Director of Nursing to the monthly Quality Assurance Performance Improvement meetings for review and recommendations. This committee will determine if any revisions are needed to the audit plan. The Quality Assurance Performance Improvement Committee consists of Administrator, Medical Director, Director of Nursing, Assistant Director of Nursing, Human Resources, Minimum Data Set Coordinator, Treatment Nurse, Admissions Director, Business Office Manager, Rehab Manager, Medical Records, Social Services, Facilities Management Director, Dietary Manager, and Activity Director. Dietician and Pharmacist reports are reviewed, and these consultants attend as needed.	5/26/11

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F 333	Continued From page 33 protect the resident's safety and welfare. b. The attending physician is notified promptly ...c. The physician's orders are implemented, and the resident is monitored closely for 24 to 72 hours as directed." Interview in the 300 Hall on May 4, 2011, at 8:30 a.m., with LPN #1 verified LPN #1 had administered a 1 ml (20 mg) amount of MSO4 (morphine) at 7:00 a.m., and 11:00 a.m., on February 22, 2011, (instead of the 2 mg ordered by the physician). Interview continued, after the DON joined the interview, and LPN #1 stated no one had ever explained the 1.0 ml amount was not the 0.1 ml dose LPN #1 had recorded as given, but ten times that amount. Interview on May 4, 2011, in the conference room with the DON at 8:45 a.m., immediately following the interview with LPN #1, verified the DON had not followed the facility policy when the significant medication error occurred. Interview confirmed if the dosing by the night shift LPN #2 and the day shift LPN #1 had been in the appropriate amount (including one wasted dose) there would have been 27.5 ml 'Quantity Remaining' when the evening shift LPN #7 was conducting the narcotic count at 3:00 p.m., on February 22, 2011. Interview confirmed, instead of 27.5 ml liquid morphine remaining, there were 20 ml remaining according to the DON. Interview confirmed the DON did not investigate the 7.5 ml (equaling 150 mg) of liquid morphine not accounted for on February 22, 2011. Interview continued and confirmed the DON did not assess the resident, did not notify the physician, and left the facility without resolution of the narcotic discrepancy.	F 333		

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F 333	Continued From page 34 On February 22, 2011, in a 10 hour period, resident #20 received 100 mg of morphine instead of the ordered 10 mg. Incorrect doses were given on February 22, 2011, at 1:00 a.m., 3:00 a.m., 5:00 a.m., 7:00 a.m., and 11:00 a.m. The Immediate Jeopardy was effective from February 22, 2011, through May 6, 2011, and was removed on May 6, 2011. An acceptable Allegation of Compliance, which removed the immediacy of the jeopardy, was received and corrective actions were validated on site by the survey team on May 6, 2011 through review of facility documents, staff interviews, and observations. The survey team verified the allegation of compliance by: 1.) Verifying one nurse involved in the significant medication error was no longer employed by the facility; and verified the other remaining nurse involved in the significant medication error had been counseled and educated regarding medication administration and had completed return demonstration of medication administration of liquid narcotics on May 6, 2011. The Director of Nursing on site at the start of the survey had resigned without notice on May 4, 2011 and an interim Director of Nursing had been established on May 4, 2011. 2.) Verifying all liquid narcotics records were reviewed by the Regional Director of Clinical Services and a Registered Nurse on May 4, 2011 to confirm accuracy of the Medication Administration Records and the Narcotic Count Sheets to determine if other residents were affected. In addition the surveyors conducted observation of liquid narcotic administration on	F 333		

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F 333	Continued From page 35 May 6, 2011. 3.) Verification by the survey team on May 6, 2011 ensured by interviews with the licensed nursing staff and review of in-service logs that the nurses received information regarding the five rights of medication administration; alert charting to be initiated on every shift for seventy-two hours after a medication error; timely notification of the Physician, Director of Nursing and the Administrator after a medication error; and notification of revision of the medication policy addressing the change of administration of liquid narcotics requiring verification and signatures by two nurses if the amount to be administered is less than 5 milliliters. The survey team verified the facility's Audit Form for Medication Error Notification to begin May 5, 2011 and be conducted daily through May 19, 2011 then decreased to two times weekly for two months through July 19, 2011. Compliance to be conducted by the Regional Director of Clinical Services. 4.) The survey team verified the facility's plan of daily monitoring by a Registered Nurse for a two week duration, beginning May 5, 2011 through May 19, 2011, then two times a week for two months until July 18, 2011 to include a 100 % audit of Medication Error Sheets for proper notification of the Physician, Administrator, and Director of Nursing; a 100 % audit of the Medication Administration Records of residents receiving liquid narcotic doses less than 5 milliliters to ensure compliance of two nurses verifying the dose and signing the Medication Administration Record; and auditing of the alert charting log against the medication error reports	F 333		

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F 333	Continued From page 36 to verify alert charting compliance for 72 hours. The survey team verified the facility's plan for the Regional Director of Clinical Services to perform a compliance review of 100% of the audit forms and related data weekly until the end of the monitoring time. The survey team verified the facility's plan to relay results to the Quality Assurance Performance Improvement committee monthly through the end of the monitoring time for review and recommendations. The survey team verified the facility's plan to have the Quality Assurance Performance Improvement committee determine if any revisions are needed to the audit plan. The survey team verified the facility's plan to have the Quality Assurance Performance Improvement committee consist of, at a minimum, the Administrator, Director of Nursing, Medical Director, and Dietary, Activities, Maintenance, Business office, Social Services, and Pharmacy departments. Non-compliance continues at a "D" level for monitoring of corrective actions. The facility is required to submit a plan of correction. c/o #27994	F 333		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control	F 441	**F441** 1. The small refrigerator was removed from the laundry area on 5/4/11by Facilities Management Director. On 5/4/11 the lift slings hanging on the walls of the soiled side of the laundry room were laundered by Facilities Management Director.	

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F 441	Continued From page 37 Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the separation of soiled and clean areas in the laundry room designed to prevent the cross- contamination of clean and soiled linen for one of one laundry room. The findings included:	F 441	2. The laundry area was reconfigured by the Facilities Management Director on 5/4/11 to allow soiled linen to enter through a separate doorway, preventing crossing of soiled and clean linens during transport. A door now separates the soiled and clean areas of the laundry. No residents were identified to be affected. 3. All nursing, dietary, activities, social services, housekeeping, laundry, facilities management, and administrative staff has been inserviced by Administrator, Interim Director of Nursing, Regional Director of Clinical Services, Facilities Management assistant on 5/5/11 – 5/24/11 regarding this change in transport of soiled and clean linens. All new employees will be trained in laundry transport protocol. 4. Beginning 5/25/11 a daily audit will be completed by Facilities Management Director or Manager on Duty for two weeks then three times a week for three months and/or 100% compliant with proper transport of clean and soiled linens to the laundry. All audit results will be reported by the Facilities Management Director to the monthly Quality Assurance Performance Improvement meetings for review and recommendations. This committee will determine if any revisions are needed to the audit plan.	

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F 441	Continued From page 38 Observation of the laundry room with the Director of Maintenance on May 2, 2011 at 9:30 a.m., revealed the entry door leading into the laundry room from the hall opened to the left. Continued observation revealed the folding table for clean laundry and the clean laundry area were directly to the right of the door opening where the soiled linen barrels enter the laundry room. Continued observation revealed the soiled linen barrels would roll within one to two inches of the folding table in order to be brought into the laundry room. Continued observation revealed a small refrigerator located on a table for the holding of clean linens. Continued observation revealed four clean lift slings hanging from hooks on the wall of the soiled side of the laundry room and touching the soiled barrels. Interview in the laundry room with the Maintenance Director on May 2, 2011 at 9:30 a.m., confirmed the soiled linen barrels have to roll no more than two inches past the clean linen folding table to gain entry to the laundry room; staff's personal refrigerators were not to be in the laundry room; and the clean lift slings were not to be stored in the soiled area of the laundry room. Continued interview confirmed the laundry room configuration was not set up to eliminate the crossing of soiled and clean linens.	F 441	The Quality Assurance Performance Improvement Committee consists of Administrator, Medical Director, Director of Nursing, Assistant Director of Nursing, Human Resources, MDS, Treatment Nurse, Admissions Director, Business Office Manager, Rehab Manager, Medical Records, Social Services, Facilities Management Director, Dietary Manager, and Activity Director. Dietician and Pharmacist reports are reviewed, and these consultants attend as needed.	5/26/11
F 490 SS=J	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.	F 490	F490 1. Immediately upon notification to the Administrator on 3/4/11 by Director of Nursing of medication error which occurred on 2/22/11, Administrator educated Director of Nursing on 3/4/11 on the Policies and Procedures for narcotic counts, notification of change, and the incident event management procedure.	

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F 490	Continued From page 39 This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility documents, review of facility policy, review of narcotic count sheets, and interview, the facility Administrator failed to ensure the safe administration of medications; failed to ensure a comprehensive investigation of an inaccurate narcotic reconciliation; failed to ensure the physician was notified of significant medication errors; and failed to ensure a comprehensive investigation of significant medication errors for one (resident #20) of thirty-one resident reviewed. The facility's failure was likely to cause serious injury, harm, impairment or death to resident #20. The Administrator and Corporate Nurse Consultant were informed of the Immediate Jeopardy on May 4, 2011, at 12:05 p.m., in the Administrator's office. The findings included: Interview with the Administrator in the Administrator's office on May 4, 2011 at 9:45 a.m., verified the Administrator was aware of the significant narcotic medications errors (no date known but shortly after the errors) and confirmed the Administrator did not ensure the safe administration of medications for resident #20; did not ensure a comprehensive investigation of of an inaccurate narcotic reconciliation on February 22, 2011; did not ensure the safety of resident #20 after a significant medication error; did not ensure the physician was notified of a significant medication error for resident #20; and	F 490	All licensed nurses were educated by Regional Director of Clinical Services, Director of Nursing and Admissions Nurse on 5/4/11 – 5/20/11 on the following requirements: verification of any liquid narcotic less than 5 mls by a second nurse who must also initial Medication Administration Record. Inservices also included the Five Rights of Medication Administration, alert charting to be initiated on every shift for seventy-two hours after a medication error, timely notification of the Physician, Director of Nursing and the Administrator after a medication error. The Medical Director and Pharmacy Consultant will be advised by the Administrator or the Director f Nursing of any medication administration error and will be included in the investigation process through the Quality Assurance Performance Improvement process. 4. Daily monitoring by a Registered Nurse for two weeks, beginning May 5, 2011 through May 19, 2011, then two times a week for three months until August 18, 2011 and/or until 100% compliant, to include a 100% audit of Medication Error Sheets for proper notification of Physician, Administrator, and Director of Nursing; a 100% audit of the Medication Administration Records of residents receiving liquid narcotic doses less than 5 milliliters to ensure compliance of two nurses verifying the dose and signing the Medication Administration Record; and auditing of the alert charting log against the medication error reports to verify alert charting compliance for 72 hours.	

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F 490	Continued From page 40 did not ensure a comprehensive investigation of a significant medication error for resident #20. REFER TO F - 157 for failing to notify the physician REFER TO F - 281 for failing to take professional responsibility to fully investigate significant medication errors REFER TO F - 333 for failing to prevent significant narcotic medication errors The Immediate Jeopardy was effective from February 22, 2011, through May 6, 2011, and was removed on May 6, 2011. An acceptable Allegation of Compliance, which removed the immediacy of the jeopardy, was received and corrective actions were validated on site by the survey team on May 6, 2011 through review of facility documents, staff interviews, and observations. The survey team verified the allegation of compliance by: 1.) Verifying one nurse involved in the significant medication error was no longer employed by the facility; and verified the other remaining nurse involved in the significant medication error had been counseled and educated regarding medication administration and had completed return demonstration of medication administration of liquid narcotics on May 6, 2011. The Director of Nursing on site at the start of the survey had resigned without notice on May 4, 2011 and an interim Director of Nursing had been established on May 4, 2011. 2.) Verifying all liquid narcotics records were reviewed by the Regional Director of Clinical	F 490	Medication administration errors will be reviewed daily by the Administrator, Director of Nursing or Assistant Director of Nursing to assure event management processes are in place and investigation is begun. Administrator will consult with Medical Director and Pharmacy Consultant on all medication administration errors, to assure each is involved with the investigation and analysis of the event. Orders and dosages will be reviewed by the Administrator with both the Medical Director and Pharmacy Consultant for accuracy and clarity. Results of the completed investigation will be reported to the Medical Director and Pharmacy Consultant by the Administrator upon closure of the investigation. Administrator will continue to recruit and hire a Director of Nursing for this facility, and will assure the new Director of Nursing receives thorough training in all aspects of the job including the Event Management system and the Quality Assurance Performance Improvement process. The Regional Director of Clinical Services will perform a compliance review of 100% of the audit forms and related data weekly until the end of the monitoring time. All audit results will be reported by the Director of Nursing to the monthly Quality Assurance Performance Improvement meetings for review and recommendations. This committee will determine if any revisions are needed to the audit plan.	

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F 490	Continued From page 41 Services and a Registered Nurse on May 4, 2011 to confirm accuracy of the Medication Administration Records and the Narcotic Count Sheets to determine if other residents were affected. In addition the surveyors conducted observation of liquid narcotic administration on May 6, 2011. 3.) Verification by the survey team on May 6, 2011 ensured by interviews with the licensed nursing staff and review of in-service logs that the nurses received information regarding the five rights of medication administration; alert charting to be initiated on every shift for seventy-two hours after a medication error; timely notification of the Physician, Director of Nursing and the Administrator after a medication error; and notification of revision of the medication policy addressing the change of administration of liquid narcotics requiring verification and signatures by two nurses if the amount to be administered is less than 5 milliliters. The survey team verified the facility's Audit Form for Medication Error Notification to begin May 5, 2011 and be conducted daily through May 19, 2011 then decreased to two times weekly for two months through July 19, 2011. Compliance to be conducted by the Regional Director of Clinical Services. 4.) The survey team verified the facility's plan of daily monitoring by a Registered Nurse for a two week duration, beginning May 5, 2011 through May 19, 2011, then two times a week for two months until July 18, 2011 to include a 100 % audit of Medication Error Sheets for proper notification of the Physician, Administrator, and	F 490	The Quality Assurance Performance Improvement Committee consists of Administrator, Medical Director, Director of Nursing, Assistant Director of Nursing, Human Resources, Minimum Data Set Coordinator, Treatment Nurse, Admissions Director, Business Office Manager, Rehab Manager, Medical Records, Social Services, Facilities Management Director, Dietary Manager, and Activity Director. Dietician and Pharmacist reports are reviewed, and these consultants attend as needed.	5/26/11

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HILLCREST HEALTHCARE SOUTH	1758 HILLWOOD DRIVE KNOXVILLE, TN 37920

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 490	Continued From page 42 Director of Nursing; a 100 % audit of the Medication Administration Records of residents receiving liquid narcotic doses less than 5 milliliters to ensure compliance of two nurses verifying the dose and signing the Medication Administration Record; and auditing of the alert charting log against the medication error reports to verify alert charting compliance for 72 hours. The survey team verified the facility's plan for the Regional Director of Clinical Services to perform a compliance review of 100% of the audit forms and related data weekly until the end of the monitoring time. The survey team verified the facility's plan to relay results to the Quality Assurance Performance Improvement committee monthly through the end of the monitoring time for review and recommendations. The survey team verified the facility's plan to have the Quality Assurance Performance Improvement committee determine if any revisions are needed to the audit plan. The survey team verified the facility's plan to have the Quality Assurance Performance Improvement committee consist of, at a minimum, the Administrator, Director of Nursing, Medical Director, and Dietary, Activities, Maintenance, Business office, Social Services, and Pharmacy departments. Non-compliance continues at a "D" level for monitoring of corrective actions. The facility is required to submit a plan of correction. C/O #27994	F 490		